UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

VYVANSE (lisdexamfetamine dimesylate)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

- Therapy to be initiated between the FDA-approved ages of 6-12.
- Documented diagnosis of ADHD.
- Vyvanse must be more cost-effective than the patient's current ADHD therapy.
- Vyvanse must follow an unsuccessful trial of a dextroamphetamine.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone call from physician office or pharmacy